AHCCCS is Arizona's Medical Assistance Program (Medicaid)

Authorization for the Disclosure of Protected Health Information

Customer:	AHCCCS ID:	Customer #:
Name and Address of Medical Source (include zip code)	Date:	
	Eligibility Specialist: Phone: ( ) - ext. Fax: ( ) -	

Name:	Date of Birth:
Address:	
Social Security Number (Optional, this may assist the health care provider in locating your records):	

Purpose of Disclosure: I am authorizing you to provide protected health information or records and any information contained in such documents to AHCCCS and/or the Arizona Department of Economic Security, Disability Determination Services Administration so that AHCCCS can determine my eligibility for any of the publicly funded programs administered by AHCCCS.

Confidentiality: I understand that AHCCCS is required by state and federal laws to keep the information described in this authorization confidential and may only disclose that information with my approval, for purposes directly related to the administration of the AHCCCS program, or as otherwise permitted by law. However, AHCCCS is prohibited from disclosing to any other person, without my written permission, substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Redisclosure: I understand that in accordance with the Health Insurance Portability and Accountability Act, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, that my information may be disclosed again by that person or entity, and my information will no longer be protected by the regulations.

Consequences of not Signing this Authorization: I understand that if I revoke this authorization or refuse to sign this authorization, AHCCCS may not be able to determine my current or future eligibility for the publicly funded medical assistance programs administered by AHCCCS. As a result, my application for assistance may be denied or assistance may be discontinued.

Right to Revoke Authorization: I understand that I have the right to revoke this authorization at any time by sending a written notice of revocation to AHCCCS. This authorization will be revoked when AHCCCS receives the written revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Expiration Date: Unless revoked earlier, this authorization will expire when my application for assistance through AHCCCS is withdrawn or denied, or when my eligibility for assistance through AHCCCS ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

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Authorization for the Disclosure of Protected Health Information

Customer:	AHCCCS ID:	Customer #:

Disclosure Authorization: I give my permission for any health care provider to disclose protected health information as described in this authorization to employees or agents of the Arizona Health Care Cost Containment System (AHCCCS) or the Arizona Department of Economic Security, Disability Determination Services Administration.

The health care provider has my permission to provide AHCCCS and/or the Arizona Department of Economic Security, Disability Determination Services Administration with any oral and/or written financial and health information including:

- Any or all medical records;
- Progress notes by physicians, nurses and any other health care practitioner;
- Test results;
- X-rays or other diagnostic imaging results;
- Service plans;
- Information about health insurance coverage and insurance amounts and premiums;
- Information about how my impairment affects my ability to complete tasks and activities of daily living;
- Information about how my condition affects my ability to work;
- Medical facility admission and discharge dates (including date of death); and
- Patient trust account records.

In addition, I am authorizing the health care provider to provide AHCCCS and/or the Arizona Department of Economic Security, Disability Determination Services Administration with the following information: _____

_____

By placing my initials in front of any of the following items, I am giving the health care provider permission to include the following types of information in the disclosure to AHCCCS and/or the Arizona Department of Economic Security, Disability Determination Services Administration:

____ HIV/AIDS and communicable disease related information and/or records (as defined in A.R.S. Section 36-661)

____ Mental health information and/or records (as defined in A.R.S. Section 36-501 – 36-550.08)

____ Genetic testing information and/or records (as defined in A.R.S Section 12-2801)

____ Drug/alcohol diagnosis, treatment or referral information (as defined in 42 CFR Section 2.1 et seq) for the following purpose:

☐ To determine my eligibility for programs administered by AHCCCS

☐ Other: _____

Print Patient's Name		
Signature of Patient, Guardian, Conservator or Authorized Representative		Date
Print Name of Guardian, Conservator or Authorized Representative (if applicable):		Relationship to Patient
Signature of Witness (If signed with a mark)	Date	Relationship of Witness to Patient
Signature of Witness (If signed with a mark)	Date	Relationship of Witness to Patient